The Health of New Hampshire's Community Hospital System

A Financial Analysis

Exeter Hospital




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An Important Message to Readers of the Hospital Financial Analysis from the New Hampshire Department of Health and Human Services

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Introduction

The following Hospital Financial Analysis is a byproduct of the December 13 report, *The Health of New Hampshire's Community Hospital System*, issued by the New Hampshire Department of Health and Human Services. The individual financial narratives are part of a series of analyses addressing the financial condition of the state's health care system.

In the following report, you will find an analysis of the hospital's financial well being from 1993-1998, and **then an additional analysis** that covers the most recent period for which information is currently available, 1999. As audited financial statements for 2000 become available from the hospitals, this information will be updated.

Each hospital financial analysis is broken into five sections. These include:

- Background information on the hospital size, location, payor mix and affiliates;
- A Summary of the Financial Analysis;
- A Cash Flow Analysis;
- An Analysis of Profitability, Liquidity and Capital; and
- An Estimation of Charity Care and Community Benefits

Financial Benchmarks

Financial benchmarks include traditional measures of profitability, liquidity, solvency, and cash flow. Each of these areas of analysis is defined below. Additional information about the ratios or the nature of financial analysis can be obtained by consulting health care financial texts (Gibson 1992; Cleverley 1992).

Profitability:	Purpose	Calculation
Total Margin	Measures the organization's ability to cover expenses with revenues from all sources	Ratio of (Operating Income and Nonoperating Revenues)/Total Revenues
Operating Margin	Measures the organization's ability to cover operating expenses with operating revenues	Ratio of Operating Income/Total Operating Revenue
PPS Payment/Cost	Measures the relationship between Medicare PPS payments and Medicare PPS costs; numbers above 1 indicate that payments exceed costs	Ratio of Medicare Prospective Payment System (PPS) Payments /PPS Costs, derived from Medicare Cost Reports
Non-PPS Payment/Cost	Measures the relationship between payment and costs of all payment sources other than Medicare PPS[1]	Ratio of (Total Operating Revenue minus PPS Payments) / (Total Operating Cost minus PPS Costs)
Markup Ratio	Measures the relationship between hospital-set charges and hospital operating costs; generally only self-pay and indemnity payers pay hospital charges	Ratio of (Gross Patient Service Charges Plus Other Operating Revenue) / Total Operating Expense
Deductible Ratio	Measures the relationship between hospital's contractual discounts negotiated with (private payers) or taken by payers (Medicare and Medicaid) and hospital charges	Ratio of Contractual Adjustments/Gross Patient Service Revenue
Nonoperating Revenue Contribution	Measures the contribution of nonoperating revenues (activities that are peripheral to a hospital's central mission) to total surplus or deficit	Ratio of Nonoperating Revenues (includes unrestricted donations, investment income, realized gains (losses) on investments and peripheral activities)/Excess Revenue over Expense
Realized Gains to Net Income	Measures the contribution of realized gains (a subset of nonoperating revenues) to total surplus or deficit	Ratio of realized gains (losses)/Excess Revenue over Expense

[1] Medicare's Prospective Payment System includes only inpatient-related operating and capital costs and excludes Medicare payments for outpatient costs, which have not been part of PPS through 1998

Liquidity:		
Current Ratio	Measures the extent to which current assets are available to meet current liabilities	Current Assets/Current Liabilities
Days in Accounts Receivables	Measures how quickly revenues are collected from patients/payers	Patient Accounts Receivable/(Net Patient Service Revenue / 365)
Average Pay Period	Measures how quickly employees and outside vendors are paid by the hospital	(Accounts Payable and Accrued Expenses)/ (Average Daily Cash Operating Expenses)[2]
Days Cash on Hand	Measures how many days the hospital could continue to operate if no additional cash were collected	(Cash plus short-term investments plus noncurrent investments classified as Board Designated)/(Average Daily Cash Operating Expenses)
Solvency:		
Equity Financing Ratio	Measures the percentage of the hospital's capital structure that is equity (as opposed to debt, which must be repaid)	Unrestricted Net Assets/Total Assets
Cash Flow to Total Debt	Measures the ability of the hospital to pay off all debt with cash generated by operating and nonoperating activities	(Total Surplus (Deficit) plus Depreciation and Amortization Expense)/Total Liabilities
Average Age of Plant	Measures the relative age of fixed assets	Accumulated Depreciation/ Depreciation Expense

Hospitals As Integrated Systems of Care

Many of New Hampshire's hospitals have developed into systems of care with complex corporate organizational structures. Hospitals may be owned by a holding company or may themselves own other subsidiaries. (The hospital corporate organization charts will be made available with these financial narratives at a future date.) These individual analyses that follow attempt to isolate the hospital entity to the extent possible as the basis of analysis. This distinction is important because subsidiaries that operate within a larger hospital system may operate at higher or lower levels of financial performance than the hospital. For example, a home health agency impacted by Medicare reimbursement changes that result in an operating deficit might be directly supported by the hospital. On the other hand, an ambulatory surgical unit (or another entity within the holding company of which the hospital is a part of) with a healthy financial performance could have a positive impact on the hospital with an operating deficit.

[2] (Operating Expenses Less Depreciation Expense Less Bad Debt Expense)/365

Charity Care and Community Benefits

Each hospital financial analysis includes a section on Charity Care and Community Benefits. This section of the hospital financial narrative is more exploratory than are the other standardized financial benchmarks. For further background information or for specific information on how these measures were calculated, please see the *Analysis of Health Care Charitable Trusts in the State of New Hampshire.*

In 1999, the legislature passed the New Hampshire Community Benefits law (SB 69), which requires that all non-profit hospitals and other health care charitable trusts with $100,000 or more in their total fund balance complete a needs assessment of the communities that they serve. The legislation also calls for the hospitals and others to consult with members of the public within their communities to discuss what the provider has done in the past to meet community needs, what it plans to do in the future, and then submit the plan to the Attorney General's office.

New Hampshire's law is a reporting statute. It does not contain a dollar value or minimum threshold the non-profit trusts must meet. With this new statute, the hospitals and others are working to improve the measurement of charity care (free care) and other community benefits they provide in return for exemption from local, state and federal taxes. Since this law is relatively new, the audited financial statements used for the purpose of this community benefit analysis may not yet fully reflect the dollar value of community benefits beyond charges foregone for charity care or necessary but unprofitable services. New Hampshire's definition of community benefits is very broad; it includes free care but does not include bad debt or shortfalls in reimbursement from the Medicare and Medicaid programs.

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For More Information

Questions or comment concerning this report may be directed to the Office of Planning and Research at 603-271-5254.

MOODY'S BOND RATING: A2
STANDARD & POOR'S BOND RATING: A+

EXETER HOSPITAL, EXETER, NEW HAMPSHIRE
1993 – 1999 FINANCIAL ANALYSIS

Exeter Hospital is an 80-bed acute-care facility that primarily serves residents of Rockingham County[3]. As of 1997, private insurers followed by Medicare represented the largest percentage of payers for inpatient discharges (48% and 34%, respectively)[4].

Exeter Health Resources, Inc. is the not-for-profit (NP) parent company of the hospital. Affiliates include Exeter Healthcare (a NP nursing home), Exeter Med Real, Inc. (NP), Rockingham Visiting Nurse Association and Hospice (NP), Matrix Health, Inc. (NP), and several for-profit companies, including Exeter Medical Services, Inc., Core Health Services, Inc., Convergent Health Systems, Inc., VX Health Services, Inc., and Exeter Pediatric Association, Inc.

Summary of Financial Analysis 1993-98
Exeter hospital is financially strong. Over the six-year period, the hospital generated most of its cash from net income ($53M). High profit margins resulted from a high and stable operating margin, and increased further as investment income contributed more to the bottom line. Strong and improving profitability, liquidity and solvency ratios indicate that the hospital should be able to sustain its advantaged financial position.

Cash Flow Analysis 1993-98
Over the six-year period, this hospital generated over three-quarters of its cash from operating activities: 60% from net income and 27% from depreciation. While 9% of cash sources came from long-term borrowing increases in 1993, it is clear that the hospital could pay down its entire 15 million in long-term debt without straining its liquidity (total unrestricted cash balances exceed $60M). The largest use of cash (41% of total uses) was to increase investments in marketable securities. This provided the hospital with a large amount of liquidity (443 days unrestricted cash on hand as of 1998) and allowed it to generate a significant amount of investment income to enhance its profit margins. Investment in property, plant and equipment (PP&E), which represented 31% of total cash uses, was greater than depreciation expense. Given the relatively young age of plant, 5.8 years as of 1998, this amount of capital investment appears adequate.

Twenty-two percent of cash uses were amounts transferred to affiliates, mainly to the parent company ($18M) in the form of equity transfers, net of cash inflows from affiliates. Most of the outflow went to the parent, Exeter Health Resources, Inc.

[3] 1998 American Hospital Association Guide.
[4] 1997 data from the State of New Hampshire Department of Health and Human Services.

Ratio Analysis 1993-98[5]

Profitability

As indicated above, the hospital's profitability is very strong. Despite the increasing contribution of nonoperating income to the bottom line by 1998, operating profitability was strong and stable, due in part to the favorable payer mix of the hospital.

Total profitability was strong and stable at 13% prior to 1996, and increased further due to the increased contribution of nonoperating income to the bottom line after 1995. Realized gains on the sale of investments drove the increase in total margin from 13 to 20% between 1995 and 1997. Despite the dip in total profitability in 1998 due to the slight drop in operating margin, realized gains contributed 40% to net income and the total margin remained high at 17%. Even without the contribution of realized gains, the hospital's profitability is strong.

Liquidity

The hospital's liquidity is extremely good. The current ratio demonstrates the hospital's ability to meet current obligations 3 to 6 times over with current assets, excluding board-designated investments.

Given the increase in marketable securities, the hospital has a large amount of unrestricted days cash on hand. Even with current cash alone, the hospital had over 100 days cash on hand until 1998, compared to an industry norm of 20-30 days. With the inclusion of board-designated investments, the hospital had 443 days unrestricted cash on hand as of 1998. (Note: the jump in days cash including board designated investments between 1995 and 1996 is partly due to an accounting principle change requiring investments to be stated at market value rather than historical cost).

Days in accounts receivable from 1993 to 1995 were below 60, but jumped to almost 70 in 1998; meanwhile average pay period remained below 50.

Capital Structure

The hospital is very solvent due to growth in equity resulting from strong profitability, which minimized the need for long-term borrowing. Even after issuing over $17 M in new debt in 1993, the hospital has a less risky capital structure relative to other New Hampshire hospitals, as illustrated by the high equity financing ratio. This ratio steadily grew (favorable) after 1993, with the exception of slowed growth in 1996 and again in 1998, due to equity transfers to the parent company, $8M and $5M, respectively. By 1998, this ratio shows that approximately three-quarters of the hospital's assets are financed with equity sources. The low and decreasing (favorable) long-term debt to equity ratio further illustrates the hospital's relatively risk-free capital structure.

Debt coverage ratios indicate that the hospital can carry its debt easily. Yearly cash flows cover more than half of the hospital's total debt. In its most profitable year (1997), the hospital produced enough net income to pay back three-quarters of its total debt. Even without considering investment income, cash flows from operations can consistently cover more than 30% of the total debt. Additionally, strong and increasing debt service coverage ratios show that the hospital produces enough net income to cover debt principal and interest payments many times over.

[5] NH state medians from The 1998-99 Almanac of Hospital Financial & Operating Indicators.

Charity Care and Community Benefits

Charity care reported as charges forgone represented less than 3% of gross patient service revenues. This measure decreased as profitability increased, and by 1998 was less than 1%. This amount of free care and 100% bad debt did not meet the estimated value of its tax exemption.

The hospital did not disclose additional information about charity care in the footnotes to the financial statements.

In addition to charity care, Exeter Hospital offers HIV/AIDS services and trauma center facilities[1], which may be considered an additional charitable benefit to the community.

Cash Flow Analysis 1993 - 1999

The vast majority of Exeter's cash (55%) is generated from its profitability, both operating and non-operating, although this number is down somewhat from the aggregate amount of 60% from 1993-1998. The second largest source is non-operating adjustments (depreciation and amortization) at 27%. 10% comes from transfers from restricted to unrestricted funds, and only 7% comes from borrowing long-term debt (down from the 1993-1998 aggregate amount of 9%).

Exeter has used most of its cash to invest in marketable securities (45%; slightly higher than the 41% from the 1998 aggregate amount) and in property, plant and equipment (PP&E) (30%). Roughly $20M has been transferred to its affiliates (19%).

1999 Ratio Analysis

Profitability

The total margin has decreased from 17% in 1998 to 12% in 1999. There was an increase in income from non-operating activities however, profitability from operating activities declined from 8% in 1998 to 5% in 1999. Expenses increased more rapidly than revenues in 1999 and 1998.

Liquidity

Exeter Hospital continues to demonstrate good liquidity, although its indicators are mixed. The hospital's collection periods appear to be increasing from 70 days in 1998 to 82 days in 1999 (an unfavorable trend, considering the national average of roughly 63 days). On the other hand, Exeter is able to pay its short-term liabilities nearly 12 times over. Exeter can meet its short-term liabilities using cash alone (acid test: 1.01). Additionally, the hospital pays its vendors in 37 days (average for the state of New Hampshire), which decreased from 45 days the prior year. Including board-designated funds, the hospital has 472 days cash on hand, a highly liquid position and well above the national average of just over 100 days.

Capital Structure

Exeter Hospital demonstrates an equity financing ratio of 0.75 in 1999 (among the least leveraged in the State and far less risky than the national average), and covered its debt service coverage by 10.39 times in 1999.

Charity Care and Community Benefits

In 1999, charity care reported as charges forgone represented 1.27% of gross patient service revenue (GPSR) - up from 0.92% in 1998. The hospital also wrote off 4.35% of the GPSR as bad debt. This was down slightly from 4.41% in 1998. The audited financial statements make no specific reference to any other community benefits provided.

Summary

Overall, Exeter is in very good financial standing: high profitability, strong liquidity, very young plant, and the least leveraged capital structure in the state.

Source: Audited Financial Statements. Prepared by Nancy M. Kane, D.B.A. Harvard School of Public Health